RESEARCH ARTICLE

Treatment barriers and gender-based perceptions: Establishing gender-based treatment specialty facilities as a strategy to motivate South African young women to seek treatment for substance use disorders

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Abstract

South Africa alongside other low-middle-income countries have been some of the hardest hit by the substance use scourge. The study sought to identify and measure treatment barriers among young adults (18–29 years) living with substance use disorders, and then examine the role of gender in the perception of treatment barriers, with a view to establish gender-based treatment specialty facilities as a strategy to promote treatment seeking among young South African women. Quantitative method was used for this study, employing simple random sampling. Exploratory factor analysis and independent samples t-tests were used as statistical measures. The identified treatment barriers were found to have a larger effect on females than males. Women were considered less likely to utilise treatment services compared to males. Health promotion practitioners and policymakers can alleviate the situation by establishing gender-based treatment facilities. that respond better to women's needs.

KEYWORDS
barriers, gender, help-seeking, substance use disorder, treatment, young adults

1 | INTRODUCTION

Harmful substance use contributes significantly to the global disease burden and has been associated with profound negative consequences such as high-risk sexual behaviours, interpersonal violence, accidental deaths, drug-related crime and longer-term health effects that include liver and heart diseases, decreased productivity and relationship problems. (Bryan, 2019; May et al., 2014). Women who use substances during pregnancy are at an elevated risk of giving birth to babies with foetal alcohol spectrum disorders (FASDs) and neonatal abstinence syndrome (NAS). The recent surge in opioid use has resulted in the number of babies dependent on opioids at birth increasing five-fold (Roussos-Ross et al., 2015). In 2018, over 35 million people were reported to suffer from drug use disorders (Barati et al., 2021). South Africa remains one of the countries with the highest prevalence of SUDs (Charlson et al., 2014). Despite these alarmingly high statistics of substance use, but having some of the best treatment facilities, treatment utilisation in South Africa remains low (Charlson et al., 2014; Ngwenya et al., 2020). Attitudinal and structural barriers such as stigma, lack of perceived treatment need, fragmented services and inadequate support systems being cited as some of the commonly experienced treatment barriers. In the midst of the substance use public health crisis, women present an even more complex problem situation in that they tend to experience additional treatment barriers such as enhanced stigma (Stringer & Baker, 2018). There is need for more research on gender-based disparities in utilisation of substance use healthcare services to inform policy, such as creating gender-based, and gender-sensitive treatment facilities.

The most common forms of response to SUDs have been incorporating clinical services procedures (detoxification and stabilisation, medication, counselling), peer-led mutual help organisations such as Alcoholics Anonymous (AA) (Kelly et al., 2019). More recently, a new breed of services has emerged in the form of recovery community centres, recovery residences and collegiate recovery (Kelly et al., 2020; Kelly & White, 2012). Although there has been an expansion on approaches, there has not been a corresponding increase in people entering treatment. Harmful substance use is predicted to continue rising, particularly in the LMICs such as South Africa, and this has partly been attributed to factors such as rampant unemployment, inadequate alternative recreational activities and the reluctance or lack of willpower on the part of policymakers to regulate the production, marketing, and sale of alcohol and other drugs (Ferreira-Borges et al., 2017). The authors add that there has been a lack of resolve and commitment in LMICs to regulate the availability of alcohol and other drugs, outlet licensing, and stamping out illicit production.

With a view to develop gender-based treatment facilities as a strategy to promote women's access to, and equitable access to healthcare services, the current study aimed to answer two key research questions: (1) What are the treatment barriers, and their relative influence on young adults living with SUDs in South Africa? (2) Do significant differences exist in treatment utilisation between young men and women living with SUDs in South Africa?

The setting of this study was the Community-Oriented Substance Use Program (COSUP) in Tshwane, South Africa. COSUP is a community-oriented primary care service provider for substance use-related problems offering services such as brief interventions, social services, counselling, opioid substitution therapy, needle and syringe exchange programme and medical examinations and treatment. COSUP is run by the University of Pretoria (Department of Family Medicine) and funded by the City of Tshwane. COSUP has 17 sites across Tshwane.

2 | MATERIALS AND METHODS

In this study, the quantitative method was applied using a questionnaire.

For representativeness, the survey drew potential participants availing themselves for the study from all 17 different COSUP sites spread across Tshwane. However, due to covid regulations, two of the sites had been closed down so a total of 15 sites ended up providing participants. COSUP has healthcare workers such as

medical doctors, clinical associates, social workers and psychologists who provide screening, assessments, diagnosis and medical and counselling treatment services to clients with substance use-related problems. Healthcare workers make reference to materials such as the World Health Organisation (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) V3.0, and the WHO's International Classification of Diseases (ICD) manual.

2.1 | Participation

The study population constituted of young adults (18–29 years old) living with a SUD and participating in the COSUP project as clients receiving treatment. This particular age group was selected because South Africa has a largely youthful population, and the use of substances is largely concentrated on this population age group. (Jaja et al., 2020; Mbandlwa & Dorasamy, 2020). The peer coordinator was responsible for the recruitment of the potential participants. The peer coordinator was assisted by the peer educators stationed at the different sites. The peer educators work for COSUP and are responsible for linking up clients with the service provider, COSUP. Potential participants were selected through random sampling. A numbered list of all participants (young adults) in treatment was developed in the reference population from which the sample was selected. Random numbers were used to select the potential sample. If the potential respondent declined the invitation, they proceeded with the next name on the list. Sample size was calculated using the survey sample size calculator method with a confidence level of 95% and a margin of error of 5% (Arifin, 2018).

Using the sample size calculator (Arifin, 2018), a population of 512 yielded a sample size of 220. Applying the lottery method, the 220 participants were selected in a way that once an enumerated number corresponding to a certain participant had been picked, it could not be put back into the 'hat' for another possible selection again (Acharya et al., 2013). A total of 206 participants eventually took part in the study.

2.2 | Procedure

The procedure details how data was collected and analysed.

2.3 | Ethics

Ethical clearance was granted by the University of Pretoria's Faculty of Humanities, Department of Psychology (Reference number 20795913 HUM012/0820). The permission to carry out the study in COSUP was granted by COSUP management. Following a detailed explanation about the research, the researcher obtained informed consent from the participants. Information and consent forms were given to the potential participants to read and were also explained to the participants.

2.4 | Pilot study

For this pilot study, the survey was completed by a convenience sample of 20 COSUP clients receiving treatment. The pilot survey was administered by the researcher as a self-report questionnaire, in small groups. The major outcome measures in pilot testing are relevance, accuracy, sensitivity and missing content (Dikko, 2016). This gives the opportunity to refine the research instrument.

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2.5 | Adapting the questionnaire

An original version of a 50-item Barriers Questionnaire (BQ) (Miller et al., 1988) was considered for use. The 50-item BQ had not been scaled, and interpretation was therefore at the item level. The original BQ is freely accessible for use. The questionnaire (Supporting Information: Appendix A) was adapted to make it more sensitive to the local South African context. After assuring the face validity of the questionnaire, three experts' opinions were obtained for assessing content validity. The reliability was checked by internal consistency methods by using Cronbach's alpha. For measuring structural validity, exploratory factor analysis was done using Exploratory Factor Analysis (EFA). This was done to evaluate the characteristics of the study questionnaire by assessing the dimensionality of the questionnaire using principal components extraction and Varimax rotation. After these procedures, the preliminary 50-item BQ, 18 items were removed, resulting in a 32-item questionnaire.

2.6 | The 4-point Likert scale

A 4-point Likert scale was used to obtain numeric data on participants in the COSUP project. A 4-point Likert scale was used to avoid the tendency of individuals to opt for the 'safe' neutral opinion found in odd number Likert scales such as the 5- or 7-point Likert scales (Chyung et al., 2017). In an even number Likert scale, also called a forced Likert scale, respondents are motivated to form an opinion, rather than selecting a neutral position (Chyung et al., 2017).

Participants had to indicate on a 4-point scale to what extent a particular barrier-statement item applied to them. A score of zero means non-significance, whilst a score of three means strongly agrees that an item has an influence. Under each construct considered, item scores were summed up and transformed to a 4-point Likert-like ordinal scale ranging from 0 to 3. Low composite scores indicate less influence of that theme/factor as a barrier to help-seeking or treatment. The self-report questionnaire was administered in small groups from the 10th to the 19th of March 2021.

2.7 | Quantitative data analysis

SPSS version 27 was used for the data analysis in this study. Each item on the questionnaire was coded into the developed scales. The scales were named by the researcher, according to the high loadings of the items under the respective factors. The Cronbach's Alpha was calculated using SPSS to determine the internal consistency (reliability) of the questionnaire. To show moderate to high internal consistency, scholars such as Creswell et al. (2011) argue that a score of 0.7 to 0.9 is preferred and acceptable.

Independent samples t-test were used to compare the means of two independent groups (males and females) with the ultimate aim of establishing whether there is statistical evidence that the means of the two groups under comparison are significantly different (Kim, 2015). The η^2 was then calculated to determine the effect size, which relates to the strength of the difference between two groups.

3 | RESULTS

The results of this study are presented to address the two key research questions. The first section of the results section relates to the first research question which sought to identify treatment barriers and rank them according to their measure of influence. The second part of the result section addresses the second research question that aimed

TABLE 1 Relative strengths of barrier factors

Barrier factor	Summated mean	Rank
Fragmented service	2.5	-
Discrimination in the community and from police	2.261	1
Information gap	1.924	2
Labelling and rejection in the community and in healthcare settings	1.660	3
Lack of perceived treatment efficacy	1.504	4
Privacy concerns	1.465	5
Lack of resources and support	1.433	6
Denial and unreadiness to give up	1.306	7

TABLE 2 Fragmented service

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation
There is fragmented service	35 (17.0%)	25 (12.1%)	43 (20.9%)	103 (50.0%)	2.51	1.180

to examine the role of gender in the perception of treatment barriers, with the objective of evaluating the need and importance to create gender-specific treatment specialty facilities.

The analysis in this chapter presents frequency tables, EFA, reliability analysis and independent *t*-tests. It provides a comprehensive discussion of the implications of the results in line with the objectives of the study. Descriptive statistics were generated using frequencies for the demographic variables, namely gender.

Seven scales are presented in Table 1, ranked according to their relative strengths. The summated mean values were used to rank the barrier factors. It is important to highlight that there is one barrier item, 'there is fragmented services', which is separately presented in Table 2, and not considered for scale rankings as an individual item. The item was extracted from the 'lack of resources and support scale' which had low internal consistency despite this item having the highest mean value (mean = 2.51) compared to all items in different scales.

In the next tables, young people's perceptions of barriers are discussed using the items of each barrier factor.

3.1 | Fragmented services as a barrier to help-seeking and treatment

Fragmented services, presented as a stand-alone item, with 70.9% of the respondents confirming that fragmented service was a very important barrier to treatment. This item was more important than other items measuring lack of resources and support—as a result, the scale has a low internal consistency when it included this item (Davenport et al., 2015).

3.2 | Discrimination in the community and from the police

Discrimination in the community and from the police was observed to be the most significant barrier, apart from the experience of fragmented and ineffective services. The participants' expression on how they perceive discrimination in the community and from the police is presented in Table 3.

TABLE 3 Discrimination in the community and from the police

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
The community looks down upon people using substances	11 (5.3%)	26 (12.6%)	59 (28.6%)	110 (53.4%)	2.30	0.887	1
People blame us for our condition. They say it is our own fault	11 (5.3%)	27 (13.1%)	68 (33.0%)	100 (48.5%)	2.25	0.879	2
People using substances are regarded as worthless	14 (6.8%)	25 (12.1%)	62 (30.1%)	105 (51.0%)	2.25	0.918	3
The police abuse their power by ill-treating people using substances	11 (5.3%)	31 (15%)	61 (29.6%)	103 (50.0%)	2.24	0.889	4
Summated mean	2.261						

The results in Table 3 attest to a significant influence of discrimination in the community and from the police as a barrier to help-seeking and treatment as more than 80% of respondents respectively endorsed the discrimination items (agree and strongly agree). The influence of discrimination in the community and by the police service is thus significant on help-seeking behaviour. There is strong evidence (mean 2.24) that respondents fear being harassed by the police and being unlawfully arrested. The majority (79.6%) of the respondents endorsed the perception that the police abuse their power by ill-treating people using substance as a significant barrier to seeking treatment (Table 4).

3.3 | Labelling and rejection in the community as a barrier to help-seeking and treatment

Labelling and rejection in the community and in healthcare settings were identified as a significant barrier influencing help-seeking and treatment.

3.4 | Information gap as a barrier to help-seeking and treatment

The participants using substances reported that the police lacked adequate information on substance use treatment services resulting in them sometimes indiscriminately and unlawfully arresting individuals presenting themselves for treatment and services (73.8%). This restrained them from seeking help and treatment. It is evident that some people also lacked information on the availability of help services (64.0%) and where to access help or treatment (71.8%) (Table 5).

3.5 | Privacy concerns as a barrier to help-seeking and treatment

This scale measured the influence of privacy as a determinant of help-seeking and treatment for people using substances.

Privacy concerns hindered almost half (54.4%) of the respondents to seek help as they did not like to talk about their personal life to other people. Participants (60.7%) were of the view that help was not necessary because they thought they could manage the situation on their own and did not want others to know what they were going through (Table 6).

3.6 | Lack of perceived treatment efficacy as a barrier to help-seeking and treatment

Five items were measured on this scale.

It can be observed that the item '*substance use treatment does not help*' was endorsed by more than half of the participants (58.3%). This is an indication that there could be some mixed feelings on the efficacy of treatment. Almost the same number of respondents (57.3%) responded that their *families encouraged them to alternatively seek help from pastors, religious leaders or the church* as an impediment to help-seeking and treatment. This could discourage young adults from seeking treatment (Table 7).

3.7 | Lack of resources and support as a barrier to help-seeking and treatment

The findings on lack of resources and support as a barrier to help-seeking and treatment among young adults living with substance use disorders are presented in Table 8.

TABLE 4 Labelling and rejection in the community and in healthcare settings

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
We feel not accepted across different places and settings	17 (8.3%)	32 (15.5%)	83 (40.3%)	74 (34.9%)	2.04	0.920	1
I feared the shame and embarrassment of being called names	35 (17.0%)	39 (18.9%)	60 (29.1%)	72 (35.0%)	1.82	1.092	2
I feared losing my identity by being viewed as an outcast	36 (17.5%)	41 (19.9%)	65 (31.6%)	64 (31.1%)	1.76	1.076	3
I was afraid the community would isolate me	54 (26.2%)	41 (19.9%)	64 (31.1%)	47 (22.8%)	1.50	1.112	4
Healthcare workers mistreat people using substances.	85 (41.3%)	43 (20.9%)	35 (17.0%)	43 (20.9%)	1.17	1.181	5
Summated mean	1.660						

TABLE 5 Information gap

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
The police lack information about treatment services so you can be unfairly arrested	31 (15.0%)	23 (11.2%)	55 (26.7%)	97 (47.1%)	2.06	1.089	1
I didn't know where to go for help	28 (13.6%)	30 (14.6%)	74 (35.9%)	74 (35.9%)	1.94	1.025	2
I didn't know there is help available for people who use substances	39 (18.9%)	35 (17.0%)	66 (32.0%)	66 (32.0%)	1.77	1.096	3
Summated mean	1.924						

TABLE 6 Privacy concerns

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
I thought I could handle it on my own and did not want people to know what I was going through	42 (20.4%)	39 (18.9%)	54 (26.2%)	71 (34.5%)	1.69	1.137	1
I didn't like to talk about my personal life with other people	42 (20.4%)	52 (25.2%)	54 (26.2%)	58 (28.2%)	1.24	1.101	2
Summated mean	1.465						

TABLE 7 Lack of perceived treatment efficacy

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
Substance use treatment does not help	38 (18.4%)	48 (23.3%)	51 (24.8%)	69 (33.5%)	1.73	1.114	1
Our families encourage us to seek help from pastors and religious leaders	47 (22.8%)	41 (19.9%)	56 (27.2%)	62 (30.1%)	1.65	1.137	2
Churches provide better services	53 (25.7%)	42 (20.4%)	50 (24.3%)	61 (29.6%)	1.58	1.165	3
I didn't think treatment would do any good	60 (29.1%)	41 (19.9%)	43 (20.9%)	62 (30.1%)	1.52	1.200	4
Treatment does not work	105 (51.0)	27 (13.1%)	34 (16.5%)	40 (19.4%)	1.04	1.207	5
Summated mean	1.504						

TABLE 8 Lack of resources and support

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
We don't get moral support from our families	43 (20.9%)	33 (16.0%)	74 (35.9%)	56 (27.2%)	1.69	1.086	1
Substance use healthcare sites are too few and far from where I stay	65 (31.6%)	47 (22.8%)	47 (22.8%)	47 (22.8%)	1.37	1.152	2
Substance use healthcare sites lack enough healthcare workers	76 (36.9%)	41 (19.9%)	52 (25.2%)	37 (18.0%)	1.24	1.135	3
Summated mean	1.433						

Two-thirds of the participants (63.1%) reported that they do not get moral support from their families. This is an indication that lack of support is an active barrier to help and treatment services among young adults using substances.

Almost half (45.6%) of the respondents reported that there are too few services where they stay. They also indicated a lack of health care workers in health care sites (43.2%). This can be attributed to lack of adequate resources.

3.8 | Denial and unreadiness to give up as a barrier to help-seeking and treatment

Denial and unreadiness to give up was the least endorsed barrier to help-seeking and treatment. The findings are presented in Table 9.

Around 48.1% respondents confirmed that '*my substance use seemed fairly normal to me*' and therefore they did not believe that they needed help. The modest means for the denial items however indicate that the respondents were not inclined to believe that denial is a strong barrier to help-seeking and treatment. Compared to other factors, denial was not highly rated as a barrier. This is confirmed by the fact that as many as 30.1% and 35.4% of the respondents respectively opted for the 'strongly disagree' response when presented with the items '*my substance use seemed fairly normal to me*' and '*I didn't think I needed any help*'.

The responses confirming that '*I liked using substances*' and '*I was not ready to give up*' was endorsed by almost half of the respondents (42.3%), slightly surpassing those rejecting that (36.9%). This was an indication that the unreadiness to give up item has a relatively modest influence as a barrier to help-seeking.

3.9 | Gender differences in perception of treatment barriers

In line with one of the quantitative research objectives of this study (to investigate and measure the influence of the gender variable on participants' perceptions on the various barriers to help-seeking and treatment), the means for demographic variables (namely gender) were compared against the independent t-test constructs. This was done to determine any evidence of significant statistical difference of the means of the two groups.

A value of $p < 0.05$ was regarded as a statistically significant difference for the independent samples t-test presented in Table 10.

From Table 10, men and women differed significantly on their perception of discrimination in the community and from the police ($p < 0.001$), labelling and rejection in the community and in healthcare settings ($p < 0.001$), information gap ($p = 0.003$) and lack of perceived treatment efficacy ($p = 0.019$). Women regarded these barriers as more important than males. Men and women did not differ significantly on the perception of denial and unreadiness to give up, privacy concerns and lack of resources and support.

To establish the strength of the difference between two groups (effect size) McLeod (2019), the η^2 is calculated using the following formula:

$$\eta^2 = \frac{t2}{t2 + (N1 + N2 - 2)}$$

The η^2 value was then compared with Cohen's 1988 guidelines cited in Morris and Fritz (2013) which state that 0.01 is small effect, 0.06 is moderate effect, and 0.14 is large effect (Table 11).

Gender had a large effect on the roles of discrimination in the community and from the police, and labelling and rejection in the community and in healthcare settings as barriers to SUD treatment. The scales had respective η^2 values of 0.484 and 0.175 (>0.14) The perception of discrimination in the community and from the police is significantly larger among the females compared to the males.

TABLE 9 Denial and unreadiness to give up

Description of item	Strongly disagree	Somewhat agree	Agree	Strongly agree	Mean	Standard deviation	Rank
My substance use seemed fairly normal to me	62 (30.1%)	45 (21.8%)	55 (26.7%)	44 (21.4%)	1.39	1.129	1
I didn't think I needed any help	73 (35.4%)	43 (20.9%)	53 (25.7%)	37 (18.0%)	1.26	1.126	2
I liked using substances and was not ready to give up	76 (36.9%)	43 (20.9%)	44 (21.4%)	43 (20.9%)	1.26	1.164	3
Summated mean	1.306						

TABLE 10   Group statistics on results of independent sample *t*-test between males and females

Scale	Gender	Mean	Std. deviation	*p*
Discrimination in the police and from the community	Male	1.4620	0.71596	0.000
	Female	2.6286	0.37930	
Labelling and rejection in the community and in the healthcare settings	Male	2.1637	0.68509	0.000
	Female	2.7357	0.41098	
Information gap	Male	1.8460	0.84733	0.003
	female	2.3048	0.72927	
Privacy concerns	Male	1.5614	0.78505	0.560
	Female	1.6667	1.00000	
Lack of perceived treatment efficacy	Male	1.4480	0.73199	0.019
	Female	1.7771	0.83704	
Lack of resources and support	Male	1.3119	0.81821	0.607
	Female	1.4095	1.05125	
Denial and unreadiness to give up	Male	1.2593	0.87431	0.153
	Female	1.5333	1.04224	

Note: *p* < 0.05 significant value.

Gender had a moderate effect on the role of information gap as a barrier to SUD treatment, with an η^2 value of 0.50 (<0.6). Gender had a small effect on the role of information gap, with an η^2 value of 0.02. The other variables, gender did not show some significant effect.

4 | DISCUSSION

The treatment barriers such as stigma, fragmented services, lack of perceived treatment need and information gap identified in this study are consistent with those that have been observed in other related studies (Frazer et al., 2019; Livingston, 2020). When one examines treatment barriers across different studies, it is evident that the existence and influence of these barriers differ from one place to another (Perron et al., 2009). Treatment barriers such as stigma-related barriers, fragmented services and information gap were found to exert a large influence on help-seeking behaviour in this study. Such observations have also been made in other similar settings (low resource and low mental health awareness settings) (Stringer & Baker, 2018). Policymakers are urged to design programmes that prioritise to address these impediments to health services utilisation. An almost similar pattern was observed when the researcher examined the effect of gender on perception of treatment barriers. Gender was found to have a large effect on the perception of stigma-related barriers. It has also been documented that women tend to experience additional treatment barriers owing to their perceived societal role as caregivers, maternal responsibilities, pregnancy, need to provide childcare and less partner support (Brady & Ashley, 2005; Greenfield & Grella, 2009; Greenfield et al., 2007).

The findings of this study suggest that there is need for provision of gender-specific and gender-sensitive treatment programmes to promote greater access for South African women living with SUDs. The findings reveal that the perception of barriers is higher among women than men, implying that treatment barriers have a more significant impact on women compared to men. Substance use healthcare centres may be encouraged to adopt

TABLE 11 Independent samples test-Levene's test for equality of variances and η^2 values

		F	Sig.	t	df	Sig. 2-t	η^2
Discrimination in the community and from the police	Equal variances assured	14.861	0.000	−9.362	204	0.000	-
	Equal variances not assured	-	-	−13.837	91.899	0.000	0.484
Lack of perceived treatment efficacy	Equal variances assured	1.635	0.202	−2.364	204	0.019	-
	Equal variances not assured	-	-	−2.163	45.255	0.036	0.02
Labelling and rejection in the community and in healthcare settings.	Equal variances assured	11.704	0.001	−4.761	204	0.000	-
	Equal variances not assured	-	-	−6.574	78.589	0.000	0.175
Denial and unreadiness to give up	Equal variances assured	3.989	0.047	−1.633	204	0.104	-
	Equal variances not assured	-	-	−1454	44.316	0.153	-
Information gap	Equal variances assured	1.180	0.279	−2.983	204	0.003	-
	Equal variances not assured	-	-	−3.294	54.552	0.002	0.050
Privacy concerns	Equal variances assured	5.492	0.020	−0.688	204	0.492	-
	Equal variances not assured	-	-	−0.587	42.982	0.560	-
Lack of resources and support	Equal variances assured	6.944	0.009	−0.611	204	0.542	-
	Equal variances not assured	-	-	−0.518	42.822	0.607	-

Note: The t-values used for the η^2 values calculations for the different constructs were derived from Table 11.

gender-specific and gender-sensitive programmes because some women may prefer women-only programmes, with women's health-specific support services (Weisner 2005). These may include matching therapist-client gender as some women may prefer women-only programmes (especially those childcare support systems and networks and coming from a background of sexual abuse and gender-based violence), provision of ancillary services for the pregnant and perinatal women (Greenfield et al., 2007). Also, men with posttraumatic stress disorder (PSTD) from military exploits or other incursions of a traumatising nature may benefit from men-only programmes.

4.1 | Limitations

The distinct numerical supremacy of males over females (males = 171; females = 35) could affect the accuracy of the results in the study. The study lacked a balanced gender representation of the participants.

Barriers to treatment are to a certain extent context-specific, and therefore the generalisation of results obtained in one context, to other settings, may be limited. To cater for cultural and contextual variations, these studies need to be conducted in different global settings so that contextually relevant interventions can be implemented. Another drawback for the study is that to make comparisons and discussion of the findings from this study, there was need for significant literature to refer to. However, there is limited literature on gender-specific treatment facilities (Westermeyer & Boedicker, 2000).

5 | CONCLUSION

From the findings of this study, it can be pointed out that South African young women are at a disadvantage in accessing substance healthcare services. As evident from the study, there needs to be policy formulation and implementation to address pertinent issues such as stigma, lack of information, as well as lack of perceived treatment efficacy. These were the treatment barriers that were observed to have a significantly high impact on women than men. Furthermore, the establishment of gender-specific treatment specialties should be tailor-made to provide environments where women can receive treatment while being able to breastfeed, and receive other women health-specific support services. This will potentially go a long way in addressing gender-based inequities in utilisation of substance use treatment services. However, the literature on gender-based differences on perception of substance use treatment barriers is evidently scanty. This study could be pivotal in offering some insights into evidence-based interventions to inform policy and address low treatment utilisation among women.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.